PROACTIVE
CHIROPRACTIC AND PHYSICAL THERAPY

Patient Intake Form - (Rev.01212022)

Please take a moment to fill out our intake form before your visit. All information is kept completely confidential.

If you are unable to complete the intake forms before your appointment, please arrive 20-30 minutes before your scheduled appointment time, and allow additional time for parking and sanitizing.

COVID-19 REQUIREMENTS. If you feel ill or have recently traveled, we ask that you reschedule your visit after 14 days. Masks are required at all times while in the office. We ask that you wash your hands after you enter the building. A sink and antibacterial soap are available as you enter the office hallway. To reduce contact we ask that you make payments and appointments through the patient portal.

Important Parking Information: Please note that our suite cannot be reached through the front of the building. Drive around the left side of the building and enter in the back at Suite 212. We are marked by a large black ramp and blue mailbox. Our reserved patient parking spots are next to the blue mailbox directly in front of our entrance.

For your appointment: Bring your ID, health insurance card, and referral or authorization, if applicable.

Insurance: If you are using health insurance, please provide all of the information listed in the insurance section. If you were involved in an accident (auto,workers comp,etc), please provide your claim information. If your health insurance requires a referral, or if you are a physical therapy patient with Medicare coverage, please bring a referral from a medical doctor.

Section 1

Demographic Information

Please check the appropriate box and fill out the information for our records.

Name	
Email	
Phone	Home: Mobile:
Address	
Sex	☐**Male** ☐**Female** ☐**Non-binary**
Date of Birth	
Guardian's Name	
Emergency Contact	
Occupation	
Employer	
Family Doctor	
Name of Referring Professional	
How did you hear about us?	
Who were you referred to?	☐**Dr. Pollack** ☐**Dr. Dispenza** ☐**Dr. Mullen** ☐**Dr. Sullivan** ☐**Bac Dinh**

Section 2

Insurance Information

If you would like to use health insurance to pay for your visit you must fill out all fields below. This will allow us to pre-check your benefits. Check the appropriate box and fill out the information.

☐ **Not using insurance**	
Patient's Name	
Patient's Date of Birth	
Name of Insurance Plan	
Member ID Number	
Group Number (if on card)	
Secondary Insurance Name	
Secondary Member ID	
Secondary Policy Holder's Name	
Secondary Policy Holder's Date of Birth	
Relationship to Policy Holder	☐**Self** ☐**Spouse** ☐**Child** ☐**Other** ☐**Not using insurance**

**If Self is not selected, please fill out information below*

Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's Address	

Chief Complaint

What is the primary reason for your visit today? *Required*

***Please describe the location of your symptoms in detail*

Please rate the severity of your pain. *Please circle one.*

0 1 2 3 4 5 6 7 8 9 10

***0 is equivalent to no pain at all_____10 is equal to "I need to go to the emergency room"*

Do you ever get shooting pain or numbness/tingling in any of your extremities? (If yes, please describe) *Required*

☐ *Yes*

☐ *No*

Was the onset of this issue: *Required*

☐ Caused by specific incident/injury

☐ Gradually worse over time

☐ Sudden but no incident/injury

Since onset, has the pain gotten: *Required*

☐ Better ☐ Worse ☐ Stayed the same

When did this episode begin? *Required*

Is this episode the first time you have experienced this pain? *Required*

☐ *Yes* ☐ *No*

When was the first occurrence of this pain? *Required*

What treatments have you received for this problem in the past? *Required*

Describe the quality of the complaint/pain. *Select all that apply.* *Required*

☐ Sharp/Stabbing ☐ Dull/Achy ☐ Pulling/Tight

☐ Tingling/Numbness ☐ Burning/Throbbing ☐ Other

On an average day, how often are you aware of your symptoms? *Required*

☐ Intermittent (less than 25% of time) ☐ Occasional (25%-50% of time)

☐ Frequent (50%-75% of time) ☐ Constant (75%-100% of time)

The symptoms are: *Select all that apply. Required*

☐ Worse in the morning ☐ Worse at night

☐ Better with activity/exercise ☐ Worse with activity/exercise

What activities make the pain worse? ***Select all that apply. Required***

☐ Sitting ☐ Standing ☐ Walking ☐ Running ☐ Lifting ☐ Sneezing/Coughing

☐ Specific Movement of Painful Area (Driving, Bending, etc) ☐ Other

What activity do you have the most difficulty with? *Required. Please select all that apply.*

☐ Sitting ☐ Driving ☐ Lifting

☐ Standing ☐ Climbing stairs ☐ Exercise

☐ Walking ☐ Running ☐ Other

What percentage capacity do you feel able to perform the above activity? *Please circle one.*

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

*** 0% is Unable to perform selected activity*

100% is No Limitation with selected activity

Which of these makes your problem better? (check all that apply) *Required. Check all that apply.*

☐ Ice ☐ Heat ☐ Sitting ☐ Standing

☐ Laying down ☐ Walking ☐ Medication ☐ Other

Have you had any changes to your bowel/bladder function? *Required*

☐ *Yes* ☐ *No*

Secondary Complaint

Please list and describe any secondary complaints you may have:

Previous Health History

Have you been treated by a Chiropractor before? ***Required***

☐ *Yes* ☐ *No*

Have you ever been treated by a Physical Therapist before? ***Required***

☐ *Yes* ☐ *No*

Please list any previous surgeries with approximate date: ***Required***

Please indicate any of the following issues/illnesses you or any immediate family members have had or currently have: ***Required. Please briefly elaborate on any history with brief description (ex. Self or Parent)***

☐ High Blood Pressure	
☐ Heart Disease	
☐ Stroke	
☐ Diabetes	
☐ Kidney Disease	
☐ Prostate Disease	
☐ Arthritis	
☐ Allergies	
☐ Scoliosis	
☐ Mental/Emotional	
☐ Skin Conditions	
☐ Multiple Sclerosis (MS)	
☐ Headaches	
☐ Cancer	
☐ Seizures	
☐ Other	

Social History

What medications, vitamins and supplements are you currently taking? ***Required***

Do you smoke cigarettes? ***Required***

☐ *Yes* ☐ *No*

Do you drink alcohol? ***Required***

☐ *Yes* ☐ *No*

How would you describe your stress level? ***Required***

☐ Mild ☐ Moderate ☐ Severe

Do you perform regular physical activity? ***Required***

☐ No ☐ Light Exercise ☐ Strenuous Exercise

What type of physical activity do you perform? ***Required***

☐Cardiovascular ☐Weight lifting ☐Walking ☐Yoga ☐Class at gym ☐Other ☐None

In general, how would you say your overall health is? ***Required***

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Would you say you have a healthy and well rounded diet? ***Required***

☐ *Yes* ☐ *No*

Are you currently pregnant? If yes, when is your expected due date? ***Required***

☐ *Yes* _____

☐ *No*

**If yes, please state your due date.*

Section 3

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

☐ I would like email notifications of new, canceled, and rescheduled appointments

☐ Email 24 hours before appointment

☐ Text Message (SMS) 1 hour before appointment

☐ Text Message (SMS) 24 hours before appointment

☐ Text Message (SMS) 36 hours before appointment

News and Special Promotions

☐ Yes, I would like to receive news and special promotions by email. Including information about our hours of operation, staff changes, new services, office events, and special discounts.

—---- Consents—----

Accuracy of Information

☐ *I certify that the above medical information is correct to the best of my knowledge.* Required

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ *I agree* Required

Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a $50 cancellation fee.

☐ *I am aware of the Cancellation Policy.* Required

Informed Consent

I request and consent to the performance of chiropractic procedures, including various modes of physical therapy and any supportive therapies on me (or the patient named for whom I am legally responsible for) by the Doctor of Chiropractic, Chiropractic Assistant, Doctor of Physical Therapy, Physical Therapy Assistant, Licensed Acupuncturist, Licensed Massage Therapist, or other support staff who now or in the future treat me while employed by, working or associated with, or serving as a backup for the staff at Proactive Chiropractic and Physical therapy whether signatories to this form or not.

I understand and I am informed that, as with all healthcare treatments, results are not guaranteed and there is no promise to a complete cure. I further understand and I am informed that, as with all healthcare treatments, in the practice of Chiropractic there are some risks to treatment. Including, but not limited to, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, fractures (in isolated cases, fractures may result from treatment), muscle soreness, stroke, and bruising. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

☐ *I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by agreeing to this form I consent to the procedures.* Required

Insurance and Payment Policy

Proactive will do their best to work with your insurance company. We will try to look up your benefits before your appointment and let you know what your out of pocket expenses will be for treatment here if the forms are received in adequate time before your appointment. Please also look up your benefits so that we are on the same page. Proactive will securely hold your credit card information to help with payment. For chiropractic services, you will never be charged more than $75 for a follow up visit and $125 for an initial or re-evaluation. For physical therapy services, you will never be charged more than $100 for a follow up visit and $150 for an initial or re-evaluation. For acupuncture, you will never pay more than $120 for follow up visits and $200 for an initial exam. Proactive's no-show fee is a standard $50.

To check your insurance benefits, we utilize the provider portal to see the information online and/or contact the provider service number for the information via a live representative. Please note that the benefit information given to us is not a guarantee of benefits and insurance may or may not cover everything. If for any reason your insurance does not cover your visit, you will be responsible to pay the out of pocket cost of services.

☐ *I understand the Insurance and Payment Policy* *Required*

Signature

_____ Date: _____

Please print First and Last name